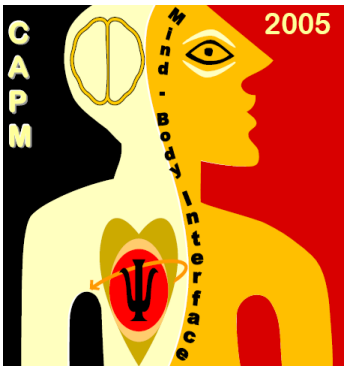


CAPM Newsletter



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CAPM Events at the 2009 CPA Meeting in Newfoundland

- CAPM Annual General Meeting, Friday, 28 August. 1200-1400h. Governor LeMarchant (Delta)
- Alleviating the Burden in Transition to Adult Care for Adolescents with Chronic Medical Disease. Drs. Brager, Geist, Granich, Russell. Friday, 28 August. 1430-1615h. Fort William C (Sheraton)
- Agitation in the Medically Ill: A Focus on Alcohol Withdrawal and Secondary Mania. Drs. Hewko and Cook. Saturday, 29 August. 10:00 - 11:45h. Harbourview G (Delta)

What is the "Liaison" in Consultation-Liaison Psychiatry?

Why is consultation to non-psychiatric units considered distinct and an area worthy of consideration as a recognized subspecialty? Clearly, as a CL psychiatrist, it is not only knowing the science behind treating the medically ill patient with psychiatric disturbance, but also the art in collaborating with care providers who are not usually trained in the psychiatric field. As Dr. Thomas Hackett wrote wisely in the Massachusetts General Hospital's seminal Handbook of General Hospital Psychiatry (Hackett and Cassem, 1978, p. 5), "A consultation service is a rescue squad. At worst, consultation work is nothing more than a brief foray

into the territory of another service...the actual intervention is left to the consultee. Like a volunteer firefighter, a consultant puts out the blaze and then returns home....(However), a liaison service requires manpower, money, and motivation. Sufficient personnel are necessary to allow the psychiatric consultant time to perform services other than simply interviewing troublesome patients in the area assigned to him." To be effective in liaison work, it involves establishing relationships with interdisciplinary staff over time so that the consultant's recommendations are implemented, mental disorders in the medically ill can be

screened for, and the subtle prejudices attached to managing mentally ill patients can be addressed and de-stigmatized. Hospital units which have embraced CL psychiatry in co-managing patients can be rewarded, ideally, with patients who suffer less morbidity, mortality, and re-admissions.

On page 6 of this newsletter, the history of the CL service at McGill is discussed and describes the preeminent Dr. Z. Lipowski's influence in introducing the concept of liaison psychiatry to that university. As Dr. Granich points out, finding a suitable name for this specialty dates back fifty years! PC

Affiliation with the World Federation of Societies of Biological Psychiatry

CAPM has an organizational affiliation with the WFSBP since CAPM was formed. WFSBP's publication is the World Journal of Biological Psychiatry. A number of treatment guidelines with a global perspective

have been published on the major mental disorders and are available online at WFSBP's website, including the most recent update on managing acute mania. The 9th World Congress is scheduled for Paris

from June 28-July 2, 2009, and is a well-attended biennial meeting. The affiliation will hopefully lead to future collaboration between the organizations in planning educational events. PC

McGill University Consultation Liaison Network (MUCLiN)

The McGill University Consultation Liaison Network (MUCLiN) is an informal network of the CL Services at five university-affiliated hospitals that provide psychiatric inpatient consultations to the medically ill population: the adult and paediatric branches of the McGill University Health Center (MUHC), the Jewish General Hospital (JGH), St. Mary's Hospital, and the Douglas Research and Hospital Institute.

MUHC adult CL staff members:



Dr. Lawrence Hoffman- Oncology, Transplantation

Dr. Annette Granich- Service Chief
Dr. Chawki Benkelfat- Internal Medicine
Dr. Marie-Josée Brouillette- HIV, Hepatitis C
Dr. Dennis Engels- Dermatology
Dr. Guillaume Galbaud du Fort- Oncology

Dr. Louis Pinard- Rheumatology/ Immunology
Dr. G. Low-Nephrology
Dr. Zorana Prelevic- Palliative Care
Dr. Baldomero Presser- Women's
Dr. R. Alec Ramsay- Pain Clinic
Dr. Asher Wilner- Neurology, Nephrology

MUHC paediatric CL members:

Dr. Ruth Russell – Psycho-oncology and Bone Marrow Transplantation
Dr. Fiona Key – Eating Disorders, Kidney Transplantation

JGH staff members:

Dr. V. Zicherman, Service Chief

Dr. K. Looper, Cancer, Somatoform CL

Dr. M. Adams, General Adult CL

St. Mary's Hospital staff members:

Drs. M. Cole and M. Elie: Geriatric CL

Dr. S. Singh: General Adult CL

Douglas Research and Hospital Institute staff members:

Dr. J. Joly, Geriatric CL

Dr M-A. Boisvert , General Adult CL

The addition of clinical nurse specialists to the services has enabled it to meet the ever increasing demands for psychosocial care. Ms. Micheline Khouzam is one of MUHC's CNS's and has started a research project based on tertiary care staff nurses' understanding and beliefs surrounding family-centred care, which has both qualitative and quantitative components.

The adult sites of the MUHC consist of the Montreal General Hospital (MGH) and the Royal Victoria Hospital (RVH), as well as the Montreal Neurological and Montreal Chest Institutes. Currently, 12 full- or part-time psychiatrists and two clinical nurse specialists provide consultation services to adult inpatients of the MUHC. The CL team provides an active teaching service. It hosts residents doing their core CL rotations, as well as residents doing 'beyond core' electives. Neurology residents do their compulsory two month psychiatry rotations half time on the service and medical students spend three half days per week in CL. A Clinical Fellowship position in CL Psychiatry is usually filled as well.

The CL Service at the JGH is staffed by two full time and one part time psychiatrists, as well as a full time nurse. Residents may do their CL core rotation on the service, and residents in other disciplines as well as medical students may do elective rotations on the CL Service. In addition to their involvement in general consultations, trainees also participate in the psycho oncology clinic and one half day a

The paediatric consultation liaison (CL) service of the MUHC is located at the Montreal Children's Hospital site. Currently, there is one paediatric psychiatrist with daily presence, a part time paediatric psychiatry nurse, and a roster of available social workers, some of whom are psychiatrically trained. There is a collaborative relationship with two outpatient paediatric psychiatry teams, each with a specific expertise in medical-psychiatric/neuropsychiatric diagnostic and intervention challenges. The inpatient CL service provides direct consultations to requesting physicians for children and their families hospitalized on medical/surgical/ICU units.

week in the perinatal mental health clinic. Specific CL activities are in the ICU, Hep C clinic, Segal Cancer Centre, and the Heart Function Clinic.

St. Mary's Hospital is the university affiliated community hospital in the network. Geriatric Medicine residents and Family Medicine 3rd year "Health Care of the Elderly" residents also engage in CL activity during a 1 month core psychogeriatric rotation in their programs.

Screening for depression in breast cancer patients: Acute distress versus persistent distress

^{1,2}Guillaume Galbaud du Fort; ³Karl Looper; ³Zeev Rosberger; ¹Jean-Paul Collet; ¹Jean-François Boivin.¹

¹Jewish General Hospital, ²Department of Psychiatry, MUHC, and ³Jewish General Hospital

Depression is relatively frequent in breast cancer patients but often remains undetected and untreated. Although several screening instruments have been developed for the detection of depression in medically ill populations, their performance remains sub-optimal. A major obstacle to the implementation of screening in daily practice is the fact that a satisfactory level of sensitivity is only obtained at the cost of a large number of false positives. Our research hypothesis is that, in a substantial proportion of distressed subjects, distress is an acute and transitory reaction to stress,

and not an indication of the presence of an underlying psychiatric disorder. To test this hypothesis, we are using a randomized design to compare two strategies for detection of depression in a sample of women being treated for breast cancer: the standard approach ("acute distress" group), where the patient is offered psychiatric assessment if she receives a high distress score (above the cutoff) at first measurement, and an alternative strategy ("persistent distress" group), where the offer of psychiatric assessment is made only if a patient with a high score at first interview is still sig-

nificantly distressed at a second interview two weeks later. After 43 months of data collection, 1545 women have been enrolled in the study, of whom 343 (22.2%) had a distress score above the cutoff. Among the 174 women randomized to the "persistent distress" group and reassessed two weeks later, 62 (39.7%) had a score below the cutoff.

We conclude distress is a transitory reaction with spontaneous recovery in approximately 40% of the cases. This should constitute a step towards the implementation of screening for depression with breast cancer treatment

Proposed and Submitted Research at McGill University

Investigation of the role of different biological systems in the etiology of interferon induced depression

**Marie-Josée Brouillette,
MD, FRCPC, MUHC**

In recent years, the role of the immune system the etiopathology of depression has been of growing interest. The treatment of hepatitis C with interferon-alpha is associated with a great incidence of clinical depression. This treatment can be used to help elucidate some the mechanisms that may lead to depressed mood. Dr. Brouillette and her collaborators at McGill will carry out a longitudinal study of factors associated with the development of depressive symptoms in a cohort of 130 patients with HCV treated with IFN- α . They will look at the effects of alterations related to the serotonin system, in neuro-immune parameters and in measures related to the HPA axis to see how they are related to the development of disturbances in mood. Because genetics plays an important role in depression, they will look at personal and family

history of mood disorders. In addition they will look at interactions between the various systems. This will provide information about which systems are associated more strongly with the development of depression and which are secondary to other systems.

Interactions Between Tamoxifen and Antidepressants via Cytochrome P450-2D6

Julie Desmarais, MD, Karl J. Looper MD, FRCPC, JGH.

Tamoxifen is a selective estrogen receptor modulator used to treat breast cancer or prevent recurrence. Recent evidence suggests that antidepressants inhibit the metabolism of tamoxifen to its more active metabolites by the CYP450-2D6 enzyme, possibly decreasing the anticancer effect. In an article in press with the Journal of Clinical Psychiatry, Drs Desmarais and Looper review the literature on the interactions between antidepressants and tamoxifen via CYP450-2D6, and offer treatment recommendations. Clinical and non-clinical studies were retrieved through Pubmed up to August 2008, including 7 clinical trials

Upcoming Canadian article from U. of

Toronto:

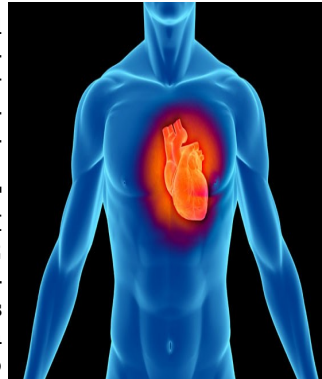
Sockalingam S, Abbey SE. Management of depression during hepatitis C treatment. CPAJ (in press for this fall)

involving tamoxifen and antidepressants. Paroxetine and fluoxetine have a large effect on the metabolism of tamoxifen and should not be used. Bupropion also strongly inhibits CYP2D6 and should be avoided. Venlafaxine has little or no effect on the metabolism of tamoxifen and is the safest choice of antidepressants. Mirazepine and desvenlafaxine have little effect and may also be considered as treatment options. The remaining antidepressants have mild to moderate degrees of CYP2D6 inhibition. Clinicians and patients may be reassured that there are safe options for the treatment of depression in women on tamoxifen.

1. Heart Disease and Psychiatry (Peter Shapiro, MD, Columbia University)

Findings continue to emerge about how specific factors impact the occurrence, morbidity and mortality of cardiovascular disease (CVD). Anxiety, although not a predictor of the onset of heart disease, does correlate with sudden cardiac death in patients with known coronary artery disease (CAD). Anger/hostility, although studies have shown mixed results as to their predictor status, appear to be related to myocardial infarction if present within 1-2 hours prior to the event. Acute mental stress has been shown to be associated with CAD and stress cardiomyopathy. Ongoing

chronic mental stress in the previous year preceding an event was associated with myocardial infarction (MI) in the INTERHEART study (n=6000 MI cases across 52 countries). Post-traumatic stress disorder has been recently shown to correlate with coronary artery disease, while depression remains a potent risk factor for CVD,



present in 70 % with new-onset CAD with no prior cardiovascular history, as well as 3-fold-to 4-fold increased risk of sudden cardiac death in those with prior MIs. The risks related to depression only drop minimally even with revascularization, still remaining 2-fold the risk of sudden cardiac death of a normal control. In terms of treatment outcome studies, all studies on SSRIs and other second-generation antidepressants show, at best, a modest benefit in terms of antidepressant

response: fluoxetine, sertraline (SADHART study- sertraline found to be safe in acute MI), citalopram (CREATE trial- citalopram more effective than placebo in stable CAD patients) and mirtazapine (MIND-IT study- mirtazapine shown to have a modest, short-term benefit but no carry-over effect in the long-term) have been studied. Psychotherapy has also been investigated in the ENRICH (CBT shown to have a modest positive benefit) and CREATE trials (IPT shown to be no better than clinical management). Survival benefit has not been adequately studied between agents, though there is a trend towards improved survival in those who remit from depression, whether in the con-

trol or treatment groups.

On the other hand, common psychiatric problems other than depression-emerging after the onset of heart disease can also affect quality of life, prognosis and mortality. Indeed, sexual dysfunction is a common corollary after a heart attack. Anxiety, while present in 5-20% of patients, has not been adequately investigated in terms of treatment and response to treatment, though there are small positive trials on CBT and relaxation training. Post-traumatic stress disorder is frequent in patients with defibrillators and has been shown recently to correlate with decreased survival, particularly in older MI patients. Delirium

and neuro-cognitive

The Canadian Cardiac Randomized Evaluation of Antidepressant and Psychotherapy Efficacy (CREATE) trial. Lespérance F, Frasere-Smith N, et al. *JAMA*. 2007 Jan 24;297(4):367-379.

changes remain under-diagnosed and can contribute to CV morbidity.

CAPM New MIT Board Member: Dr. Tuong Vi Nguyen, McGill. The 3 articles are summaries of highlights from the APA 2009 presentations she attended relating to psychosomatic medicine.

Dr. Nguyen is our new member on the CAPM Board and is enthusiastic about developing a network of members in training nationally who are interested in Consultation-Liaison Psychiatry and Psychosomatic Medicine. She is fluent bilingually, will help in

translation of the newsletter, and be the resident who can help with recruitment at McGill and other Quebec universities. Hopefully, a single resident can be identified at each major centre nationally who can help with generating interest and membership to CAPM



2. Psychopharmacology and GI disorders (Catherine Crone, MD, George Washington University)

Recent evidence highlights the importance of the brain-gut connection and the frequency of psychiatric co-morbidities in functional gastro-intestinal (GI) disorders. There is some evidence that psychotropic drugs may not only treat the psychiatric disorders associated with GI problems but may relieve the GI symptoms as well. For example, Irritable Bowel Syndrome (IBS) (7-10% of the population) has a high co-morbidity with psychiatric disorders (40-94% of patients have an axis I dis-



order). Both TCAs and SSRIs have been shown to relieve the GI symptoms of IBS. TCAs may be better for patients suffering mainly of diarrhea, while SSRIs may be better for patients suffering predominantly of constipation. GERD may also respond to adjunctive antidepressant treatment. TCAs, SSRIs, trazodone and diazepam have

all been shown to improve sleep and well-being. Inflammatory bowel disease patients also have a 3-fold increase in depressive disorders. In addition, depression is an independent risk factor for treatment failure (resistance to infliximab, a TNF-alpha antibody). Paroxetine, bupropion, and phenelzine have all been shown in recent small trials, to improve quality of life (paroxetine) and increase disease remission (bupropion and phenelzine). Mechanism of action may include decreases in TNF-alpha (bupropion) or decreased gut permeability (phenelzine).

3. Update on recent medical evidence that could impact on psychiatric care (Monique Yunahan, MD, Stanford University): The ACCORD and ADVANCE Trials

The ACCORD trial (blinded RCT, NIH sponsored) studied 10 251 patients – mean age=62 yo- with type II DM and looked at intensive tight glycemic treatment vs. routine management. Mortality was actually increased (5%) in the intensive glycemic treatment group vs. control group (4%). The rate of severe hypoglycemic events also tripled (10% vs. 3.5% in the control group), although the risk of non-fatal MI was slightly smaller (3.6% vs. 4.6%). However, there were no significant differences in cardiovascular outcomes as a whole (fatal and non-

fatal MIs). The ADVANCE trial followed 11 140 patients –mean age 66 yo- comparing sulfonylurea therapy + adjunctive oral hypoglycemic medication to non-sulfonylurea oral hypoglycemic monotherapy. There was a small, non-significant decrease in macrovascular events, with a significant decrease in microvascular events. At 5 yr fol-

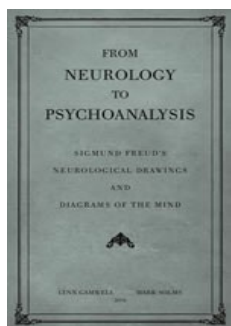
low-up there was no difference in all-cause mortality. Tight control in elderly people leads to high rates of hypoglycemic events, with some benefits in delaying microvascular events.

Lower Cognitive Functioning with Less Glycemic Control:

The ACCORD-MIND trial. Cukierman-Yaffe T, et al. *Diabetes Care*. 2009 Feb;32(2):221-6.

The 9th International Neuropsychanalysis Congress

The 9th International Neuropsychanalysis Congress was held in Montreal at the Montreal Neurological Institute on 25-28 July 2008. The congress theme was "The Self in Conflict: Neuropsychanalytic Perspectives" and the speakers included Suzanne Corkin, Todd Feinberg, Joy Hirsch,



Robert Michels, Georg Northoff, Jaak Panksepp and Mark Solms.

Asher Wilner MD from the McGill University Health Center Consultation-Liaison service was the local representative on the organizing committee.

Mark Solms donated signed copies of his book "Freud's Neurological Drawings" to the libraries of the Montreal Neurological Institute and the Allan Memorial Institute to commemorate the event.

The book can be viewed at:
artmuseum.binghamton.edu/freudbook/

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CAPM (Canadian Academy of Psychosomatic Medicine). is one of the 4 recognized academies by the CPA and comprises mostly of hospital-based Consultation-Liaison psychiatrists across the country. It was founded in 2005. One of its major objectives is working with academic institutions to develop, implement and evaluate standards of training for undergraduates, postgraduates, and psychiatrists in the field of Psychosomatic Medicine.

Membership is \$75 annually. Free for members-in-training

Please join us today!

Email for application: pechan@interchange.ubc.ca

UPCOMING PSYCHOSOMATIC MEDICINE CME EVENTS

ICPM 20TH WORLD CONGRESS. TURIN, ITALY. SEPTEMBER 23-26, 2009

ACADEMY OF PSYCHOSOMATIC MEDICINE, LAS VEGAS, NV, NOVEMBER 11-14, 2009

CANADIAN PSYCHIATRIC ASSOCIATION MEETING, ST. JOHN'S, NFLD. AUG 27-29, 2009

9TH WORLD CONGRESS OF BIOLOGICAL PSYCHIATRY. PARIS, FRANCE. JUN 28-JUL 2.

History of the CL Service at the Royal Victoria site of the MUHC *Dr. Annette Granich, Service Chief*

The CL Service at the MUHC dates back to the 1950's with the recruitment of Dr. E. Wittkower, a psychoanalyst from the United Kingdom with a special interest in dermatological disorders and hyperthyroidism. He established links with relevant medical specialists for consultation and research, and introduced the idea of a "Psychosomatic Service". In 1959 Dr. Z. J. Lipowski, who was then completing advanced CL training at the Massachusetts General Hospital, was invited to join the staff of the Allan Memorial Institute in Montreal after his fel-

lowship training. It was proposed that the existing "Psychosomatic Service" be replaced by a broader concept, with closer links to the Department of Medicine. Dr. Lipowski suggested the name 'Psychiatric Consultation Service.' The staff raised objections to this suggestion, reasoning that it could be confused with psychiatric consultations to the emergency department, and thereby lose its distinct identity, but Dr. Lipowski insisted: "My objection to the term 'psychosomatic' stems from the fact that this term too often carries the connotation of a subspecialty concerned with a small group of so-called 'psychosomatic

disorders' like peptic ulcers, etc. and thus gives an entirely distorted impression of the scope of potentially useful operations of a psychiatrist working on non-psychiatric services. For this reason I would suggest that we adopt the title 'Psychomedical Liaison Service' which seems to be more specific and accurate". In 1964 the 'Psychosomatic Consultation Service' became the Psychiatric Consultation Service". That year two young recruits, Dr. F. Lowy, trained in Cincinnati, and Dr. D. Engels, trained in Boston, and currently on staff, joined the service.